

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 23
FILED SEP 20 1961

Primary Registration District No. 3015

Registrar's No. 90

-61-032261
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Daviess</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Cameron</u>		Length of stay in 1b <u>3 Days</u>		c. CITY OR TOWN <u>R.F.D. Cameron Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Community Hospital</u>				d. STREET ADDRESS " " " " " "		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Evert</u> Last <u>Tripp</u>				4. DATE OF DEATH <u>9-9-1961</u> Month <u>9</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAUC.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1899</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Self</u>		11. BIRTHPLACE (City and state or country) <u>Dow City Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Tripp</u>			13b. MOTHER'S MAIDEN NAME <u>Lorena Galland</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>				17. INFORMANT <u>Lila McKinley Sargent Blue Iowa</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bilateral Glomerulonephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple Injuries in Auto Accident 3-4-61</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>9-2-61</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>8-4-61</u> to <u>9-9-61</u> and last saw him alive on <u>9-9-61</u> Death occurred at <u>11:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u>				22b. ADDRESS <u>Cameron Mo.</u>		22c. DATE SIGNED <u>9-12-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>9-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memory Gardens</u>		23d. LOCATION (City, town, or county) <u>Cameron Mo.</u>	
24. FUNERAL DIRECTOR <u>Poland Funeral Home</u>		ADDRESS <u>Cameron MO</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 12 1961</u>		26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 26 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Laurence J. Thompson

Licensed Embalmer No. 4735

P. O. Address Cameron Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.